EXHIBIT 4
DATE 2/11/2011
HB 396

TREATMENT PROGRAM STATEMENT AND COUNSELING AGREEMENT

Provision of the following information and written acknowledgment of its receipt are required by Montana State Law. **Please read it carefully.** I welcome the opportunity to discuss any questions or concerns you may have regarding this agreement or my services.

CREDENTIALS AND TREATMENT APPROACH

I hold a Masters of Arts degree in Applied Behavioral Science from the Leadership Institute of Seattle/Bastyr University, and am licensed by the State of Montana. My therapeutic orientation is derived primarily from Systemic Family Therapy; however, I have experience with several other orientations as well. I also welcome and encourage the use of your spiritual life as part of your counseling. Each course of treatment is unique to those who participate in it, and thus your therapy will be a blend of what you and I do together. I am responsible for developing and implementing a course of treatment that will most effectively deal with your issues. You are responsible for your decisions and for changing. This means that you must work on your issues both inside and outside of our counseling sessions. People and situations are complex, and I cannot guarantee that specific changes will occur as a result of our counseling together. I may, at various times, make suggestions and give advice, but of course, you are in control of what choices you make and how you implement them.

I ascribe and adhere to the Code of Ethics of the American Counseling Association. I must also answer to the ethical and professional standards of the Montana Board of Social Work Examiners and Professional Counselors and the Uniform Health Care Information Act.

YOUR RIGHTS AS A CLIENT:

As the client of a licensed counselor, you have the right to have information you share with me held in strict confidence unless you have given written permission to disclose it. That information also includes the fact you are receiving counseling services. **The following situations are exceptions to your right to confidentiality.**

1. If I believe you are likely to do harm to yourself or to another person, I must take steps to protect you and /or the other person.

2. If I believe you may be physically or sexually abusing or neglecting a minor child or vulnerable adult, or if you report information to me about the possible violence, harm, abuse and/or neglect of a child (from evidence or suspicion), I am required by law to report this to Child and Family Services, a state agency.

3. If you are seeing me in family or couples treatment, information shared with me in any individual meeting may be shared by me in a joint session if I feel it to be in the best interest of the work we are doing together.

4. If I am required or permitted under the Uniform Health Care Information Act to release confidential information.

In some cases it will be useful to the therapy for me to discuss your situation with others such as a physician, your former therapist, etc. In such cases, I will seek your written permission for this exchange of information. I regularly consult with colleagues and/or receive supervision regarding my work with clients to gain feedback and suggestions about directions for my growth. My work with you may be discussed in formal or informal sessions with my colleagues or with other professionals with whom I seek consultation or supervision. During these consultations, neither your last name nor other unique identifying information will be used. All discussions of this type with other professionals are subject to the same provisions of confidentiality discussed above. If someone else referred you to me, I may, as a good business practice, acknowledge to that person you have contacted me and thank them for the referral. I will not discuss your situation with them unless I have your written permission.

You always have the right to request a change in treatment or to refuse treatment. You also have the right to view, copy or request a change in your records. It is important to me that what we do together meets your needs. If you believe you are not being helped, please tell me so that we can work through the difficulty together. If we are unable to do so, I will assist you in finding alternative treatment.

My voice mail number is 443-8580. I attempt to check my messages on a regular basis. However, if there is an emergency and you are unable to reach me, please call your primary care physician or go to the nearest emergency room.

In regard to the provision of services, I will in no way discriminate on the basis of a person's race, color, sex, age, ethnic origin, religion, sexual preference, disability or any other characteristic that is protected by Federal, State, or local laws, acts or ordinances. If you feel I have behaved in an unprofessional or unethical manner, please advise me so that the problem can be clarified and resolved. Any individual (or class of individuals) who believes that he or she is a victim of discrimination may file a complaint with the U. S. Department of Justice, Civil Rights Division, Coordination and Review Section, P. O. Box 66118, Washington, D. C. 20035-6118. Complaints of unprofessional or unethical conduct may also be filed with the Montana Board of Social Work Examiners and Professional Counselors, 301 S. Park, P.O. Box 200513, Helena, MT. 59620-0513.

APPOINTMENTS AND FEES

My standard fee is $125.00 for the initial session and $95.00 thereafter. Payment of your bill is part of your treatment. The 50 minutes scheduled for your session are set aside for you. If you miss a session without canceling, or if you cancel without providing 24 hours notice, I will bill you in full for that time. Insurers will not compensate you under such circumstances. If you are late for a session, you will be seen for the remainder of your scheduled time and charged the full rate. **Full payment is due at the time of service.** I accept cash or checks. I cannot take medical coupons or barter. A $20.00 fee per check will be charged for returned checks. A finance charge of 1% per month or $.50 minimum, whichever is greater, will be assessed on balances outstanding over 90 days unless other arrangements have been made in advance. Any outstanding balance without a payment arrangement six months after the close of treatment will be turned over to a collection agency and you will be responsible for any collection fees incurred in that process.

If I am doing work related to your treatment that is outside the bounds of our scheduled counseling, I will bill you on an hourly basis for all the time I spend on your case including meeting with your attorney, writing reports, travel and preparation time. The adult accompanying a minor and the parents (or guardians) of a minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless payment arrangements have been pre-arranged.

INSURANCE

Client insurance information must be provided at or before the first session. One half of the full fee must be paid at time of service until co-payment is established. The insurance policy is a contract between you and your insurance company only. Some or all of the service I provide may not be considered reasonable or necessary under your policy, and are therefore not covered. Having applicable health insurance in no way relieves you of financial responsibility for any portion of payment, and any balance owing is your responsibility whether insurance pays or not. Funds received from insurance will be applied directly to your account. Insurance companies generally require some information regarding your treatment with me. Most insurance companies only require basic information, often including a psychiatric diagnosis. You have the right to know the diagnosis that I use in any communication with your insurance company or other third party payer or agency. All of the diagnoses I use come for the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM IV). A copy of this book is available in my library and you are free to look at it.

CLIENT CONSENT TO TREATMENT

It has been explained to me that counseling is not an exact science, and I have the right to have a clear description of the nature and character of the proposed counseling. This includes anticipated results and benefits as well as serious possible risks or complications. I also realize that I have other treatment options, including no counseling at all and that no guarantee or assurance has been made to me as to the results that may be obtained from my treatment. **My signature below verifies that:**

1. I have read or have had satisfactorily explained to me this Treatment Program and Client Agreement. I have asked any questions that I desired in regard to this agreement.

2. I have freely elected the counseling/treatment program offered in good faith and without duress.

3. I consent to the release of confidential treatment information (via phone, mail or fax) to my insurance company for billing purposes, but limit my release to only that information necessary for insurance billing purposes.

4. I give permission for the release of records deemed relevant to my ongoing health care to referring physician(s), mental health practitioner(s), or agencies upon receipt of a written authorization.

5. I understand that any therapy, testing, or other diagnostic work that is conducted by my consent may be reviewed by any colleagues or other professionals with whom Sharon Nason, M. A. may regularly consult.

6. I am aware that treatment with Sharon Nason, M. A. is not an emergency service and I have been informed of a number to call in the event of an emergency during evening and weekend hours.

7. I have received a copy of the counseling fees and have made a financial agreement for services to be rendered to me.

8. I have received a written disclosure.

9. I have been given a copy of Client Rights and Consumer Advocacy Information.

Client Signature_____ **Date**_____